THE DIVISION OF HEALTH OF MISSOURI

FILED JUN 27 1957

STANDARD CERTIFICATE OF DEATH

'57 021670 STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 95

1. PLACE OF DEATH
a. COUNTY LACLEDE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN LEBANON MO — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION WALLACE HOSP. — Length of stay in 1b 2 DAYS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY WEBSTER
c. CITY OR TOWN 1120 CONWAY MO R2 — Inside Limits Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location) 3Mi. W. CONWAY MO — Reside on Farm Yes [X] No [ ]

3. NAME OF DECEASED (Type or print) First TURNER Middle — Last VANCE

4. DATE OF DEATH Month JUNE Day 16 Year 1957

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH OCT 23 1878

9. AGE (If years last birthday) 78 — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET FARMER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME ISSAC VANCE

13b. MOTHER'S MAIDEN NAME FRANCES WILHOIT

14. NAME OF HUSBAND OR WIFE CAROLYNE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address CAROLYNE VANCE CONWAY MO R2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 24 hrs

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c) 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Prostatitis Chronic. Senile dementia

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

MEDICAL CERTIFICATION

20a. ACCIDENT SUICIDE HOMICIDE [ ] [ ] [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from June 14, 1957 to June 16, 1957 and last saw her/him alive on June 16, 1957. Death occurred at 1000 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Paul A Jenkins MD

22b. ADDRESS Knight Bldg Lebanon Mo

22c. DATE SIGNED 6-18-57

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

23b. DATE 6-18-1957

23c. NAME OF CEMETERY OR CREMATORY GOOD SPRINGS

23d. LOCATION (City, town, or county) WEBSTER Co (State) Mo

24. FUNERAL DIRECTOR ADDRESS BARBER-EDWARDS MARSHFIELD

25. DATE RECD. BY LOCAL REG. 6-18-1957

26. REGISTRAR'S SIGNATURE Ubella L. Day

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Received 6-24-57
Laclede County Health Unit
File No. 99
Date Filed 6-24-57

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 3848

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.